Benefit Options
Choice. Value. Health.

STATE OF ARIZONA ACTIVE EMPLOYEE ENROLLMENT/CHANGE 2005-2006

☐ NEW EMPLOYEE ☐ QUALIFIED LIFE EVENT ☐ ADDRESS CHANGE ☐ TERMINATION

AGENCY CODE	AGENCY	DATE AGENCY RECEIVED	EFFECTIVE DATE

DO NOT WRITE ABOVE THIS LINE - FOR AGENCY USE ONLY

A. EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	Employee ID Number or SSN	□ MALE □ FEMALE	□ MARRIED □ SINGLE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH	DATE OF EMPLOYMENT
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )	
SPOUSE'S LAST NAME, FIRST NAME	SPOUSE'S EMPLOYER	EMPLOYEE CURRENT SALARY	

B. MEDICAL PLAN (Monthly Costs Listed)

□ I DECLINE MEDICAL COVERAGE

	PLAN CODE	SINGLE	PLAN CODE	FAMILY
CENTRAL REGION: MARICOPA, GILA, & PINAL COUNTIES				
RAN+AMN (HMA) EPO	11	☐ $25.00	12	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	21	☐ $25.00	22	☐ $125.00
United Healthcare (UHC) EPO	01	☐ $35.00	02	☐ $135.00
Arizona Foundation (AZF) PPO	25	☐ $140.00	26	☐ $390.00
United Healthcare (UHC) PPO	03	☐ $150.00	04	☐ $400.00
SOUTHERN REGION: PIMA AND SANTA CRUZ COUNTIES				
RAN+AMN (HMA) EPO	09	☐ $25.00	10	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	19	☐ $25.00	20	☐ $125.00
United Healthcare (UHC) EPO	05	☐ $35.00	06	☐ $135.00
Arizona Foundation (AZF) PPO	23	☐ $140.00	24	☐ $390.00
United Healthcare (UHC) PPO	07	☐ $150.00	08	☐ $400.00
NORTHERN REGION: YAVAPAI, COCONINO, NAVAJO, AND APACHE COUNTIES				
RAN+AMN (HMA) EPO	15	☐ $25.00	16	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	35	☐ $25.00	36	☐ $125.00
Arizona Foundation (AZF) PPO	29	☐ $140.00	30	☐ $390.00
SOUTHEASTERN REGION: GRAHAM, GREENLEE, AND COCHISE COUNTIES				
RAN/AMN (HMA) EPO	13	☐ $25.00	14	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	37	☐ $25.00	38	☐ $125.00
Arizona Foundation (AZF) PPO	27	☐ $140.00	28	☐ $390.00
WESTERN REGION: MOHAVE, LA PAZ, AND YUMA COUNTIES				
RAN+AMN (HMA) EPO	17	☐ $25.00	18	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	39	☐ $25.00	40	☐ $125.00
Arizona Foundation (AZF) PPO	31	☐ $140.00	32	☐ $390.00
OUT-OF-STATE				
Beech Street PPO	33	☐ $25.00	34	☐ $125.00

Benefit Options
Choice. Value. Health.

STATE OF ARIZONA ACTIVE EMPLOYEE ENROLLMENT/CHANGE 2005-2006 CONTINUED

C. DENTAL PLAN (Monthly Costs Listed)	SINGLE COVERAGE		FAMILY COVERAGE	
☐ I DECLINE DENTAL COVERAGE	PLAN CODE		PLAN CODE	
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	03	☐ $14.56	04	☐ $54.14
METLIFE DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	07	☐ $12.90	08	☐ $45.00
EMPLOYERS DENTAL SERVICES (EDS) PRE-PAID IN-STATE ONLY	09	☐ $4.02	10	☐ $18.16
ASSURANT BENEFITS PRE-PAID IN-STATE ONLY	01	☐ $4.68	02	☐ $18.02

D. VISION PLAN (Monthly Cost Listed)

	Plan Code 05	Plan Code 06

☐ **I DECLINE VISION COVERAGE** ☐ AVESIS SINGLE COVERAGE $6.34 ☐ AVESIS FAMILY COVERAGE $17.18

E. DEPENDENTS - List all eligible dependents to be enrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, M.I. (LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER). USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS	DATE OF BIRTH (MM/DD/YY) **REQUIRED**	MEDICARE	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT Y or N	DISABLED Y or N	ADD OR DELETE A OR D
Employee		**A=Medicare A B=Medicare B C=Medicare A & B D=Medicare unknown E=No Medicare**	**S=Spouse, C=Child, G=Guardian, P=Placed for adoption, T=Stepchild**				
Spouse		☐ A ☐ B ☐ C ☐ D ☐ E	☐ S	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F			

F. STANDARD SHORT-TERM DISABILITY

☐ **I DECLINE STANDARD SHORT-TERM DISABILITY** ☐ **I ELECT STANDARD SHORT-TERM DISABILITY**

G. STANDARD SUPPLEMENTAL LIFE INSURANCE AND DEPENDENT LIFE INSURANCE

Employee coverage maximum $300,000 in multiples of $5,000 not to exceed 3 times annual salary. Increases may not exceed $20,000 per plan year.

☐ **I DECLINE SUPPLEMENTAL LIFE INSURANCE**

☐ Total amount of employee coverage $_____

☐ Non-Smoker (I have not smoked in 6 months, additional $1,000 benefit if Supplemental Life Insurance is elected).

Dependent Life Insurance

- ☐ **I DECLINE DEPENDENT LIFE INSURANCE**
- ☐ $2,000 $0.94/MTH Plan Code 02
- ☐ $4,000 $1.88/MTH Plan Code 04
- ☐ $6,000 $2.82/MTH Plan Code 06
- ☐ $12,000 $5.64/MTH Plan Code 12
- ☐ $15,000 $7.06/MTH Plan Code 15

H. PRIMARY BENEFICIARY (List additional or Trust information on a separate form which you may obtain from your benefit liaison)

Beneficiary Last Name, First Name	Social Security Number (optional)	Date of Birth

Beneficiary Street, City, State, Zip Code	Phone No. ( )

I. EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify that under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/dependent information is correct and true. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In additon, I have read and understand the declarations on the reverse side of the form.

SIGNATURE:_____ DATE:_____

Return form to: ADOA Benefits Office, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 **Revised 08/08/05**

DECLARATION FOR PRE-TAX BENEFITS

- o I authorize my employers to reduce my salary by applicable pre-tax dollars or deduct from my paycheck the applicable after tax dollars for the insurance programs that I have elected elsewhere on this form.
- o I understand that my pre-tax election made herein is irrevocable and can be changed only as of October 1, of each year, or declared open enrollment; or in the event of a qualified life event (marriage, divorce, death of a spouse or eligible dependent, birth or adoption of a child, or a child placed by court order in the employee's household, change in the status of a dependent child, change in my spouse's employment) and that I must elect this change in writing within 31 days of the qualified life event.
- o I am aware that my pre-tax plan contributions are ineligible as deductions for income tax purposes.
- o I verify that the information on reverse is true and complete and agree that it is my obligation to keep this information up-to-date.
- o I authorize release of information to my insurance carriers and employer.
- o I understand that as a "new hire" or first time enrollee my elected insurance coverage commences on the date I return to work, if am not "actively at work" on the effective date. The "actively at work" provision includes regular non-working days provided I worked the preceding scheduled work day.
- o I understand that as a new hire I have 31 days from the date of hire to enroll in my benefits, Medical, dental, vision, basic life insurance, supplemental life insurance and short-term disability. The effective date for benefit coverage will be the first day of the pay period following submission of the completed electronic enrollment and/or receipt of my properly completed election form.
- o I understand that newly elected short-term disability coverage and life increases commence on the date I return to work, if I am not "actively at work". The "actively at work" provision includes regular non-working days provided I worked the preceding scheduled work day.
- o I understand that failure to adhere to these declarations may jeopardize my insurance coverage.

ACTIVELY AT WORK PROVISION

Plan provisions require that an employee be performing the duties of his/her normal occupation in order for enrollment or increases in coverage to commence. If an employee is absent due to illness or injury, requested enrollment or increases in coverage do not commence until the employee returns to work. The actively at work provision is only applicable to life insurance and short-term disability coverage.

NEW HIRE

The effective date for benefit coverage will be the first day of the pay period following submission of the completed electronic enrollment and/or receipt of my properly completed election form. Flexible spending is effective the first day of the pay period following submission of the completed electronic enrollment and/or receipt of my properly completed election form, provided you enroll within 31 days of your date of hire. You have 31 days from your start date of hire to submit your elections.

DEPENDENT ELIGIBILITY

Eligible dependents include: Your legal spouse; Natural, adopted and/or step-children under age 19, or under 25 if a full-time student at an accredited educational institution; Minors under the age of 19 for whom the employee/member has court-ordered guardianship; Foster children under the age of 19; Children placed in the employee/member's home by court order pending adoption; natural, adopted and/or step-children who were disabled prior to age 19.

QUALIFIED LIFE EVENT CHANGES

Requests for coverage changes due to Qualifying Life Event changes (e.g. marriage, birth/adoption, divorce, etc) must be submitted either within 31 days of the date or during an annual open enrollment period.

IF YOU AND YOUR SPOUSE ARE STATE EMPLOYEES

If both you and your spouse are eligible State of Arizona employees, be sure to take into account the coverage that you each can elect.

Each of you may elect single medical, dental and/or vision plan coverage. OR, One of you may elect family medical, dental, and/or vision plan coverage while the other elects no coverage or single coverage, with different insurance plans.

Under no circumstances may an employee elect dual coverage. If it is determined there is dual coverage, you will be responsible for coordination of benefits for any claims paid under your dependent status. Health insurance premiums will not be reimbursed to either employee as a result of dual coverage.

SUPPLEMENTAL LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE and SHORT TERM DISABILITY provided by STANDARD INSURNACE

Supplemental Life Insurance and AD&D options are available to all eligible employees as new hires in $5,000 increments up to 3 times the annual salary or $300,000, whichever is less. Annual increases may not exceed $20,000. Rates may increase at the beginning of the policy year (October 1) according to an employee's age and the following premium schedule.

Employee Age

Supplemental Life Plan:	**29 and under**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70+**
Monthly cost per $5,000	$0.50	$0.60	$0.70	$1.20	$1.60	$2.60	$3.70	$6.70	$6.70	$10.60

SHORT-TERM DISABILITY PLAN

$0.89 per $100 of your monthly base salary (to a maximum of $5,000)
Monthly premium = (Monthly base salary/100) X $0.89
Example: Monthly base salary = $2,500 – ($2,500/100) X $0.89 = $22.25